

CHAPTER 5

ICF/IID Level of Care

In order to be enrolled in the Community Supports Waiver, the individual must have mental retardation or a related disability as determined by SCDDSN, be eligible to receive Medicaid, be allocated a waiver slot, choose to receive services in his/her home and community and meet ICF/IID Level of Care (the individual does not have to be currently served by SCDDSN).

Initial ICF/IID Level of Care Evaluations for the Purpose of Enrolling in the Community Supports Waiver

The Consumer Assessment Team located in the Sequoia Building at the Midlands Center Campus makes the initial determination of ICF/IID Level of Care. Once a slot has been allocated, feasible alternatives under the Waiver have been explained to the individual, and the individual has been given a choice of institutional services or home and community-based services, you must request a determination of Level of Care.

The initial determination is requested by completing the **Request for Community Supports Level of Care (Community Supports Form 9)** and forwarding information that supports this Level of Care to the Consumer Assessment Team located at the District One Office (8301 Farrow Road; Columbia, SC 29203-3294).

In addition to the Community Supports Form 9, you must forward records that support the Level of Care. These records may include:

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores that support a diagnosis of mental retardation or a related disability. Every effort should be made to locate the report that is noted on the individual's Eligibility Letter as well as any additional, current evaluation reports, if applicable.

If the individual does not have mental retardation and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be, for example, a report from the SCDDSN Autism Division, or appropriate medical, genetic or adaptive assessments. The SCDDSN Eligibility letter should always be included for those individuals who have a related disability. If the Eligibility Letter cannot be located, a print-out of the SCDDSN STS eligibility menu will suffice.

2. Current SCDDSN Service Coordination Annual Assessment and current Support Plan, Individualized Family Service Plan or Family Service Plan.
3. Any/all other current (within one year) signed and dated information pertaining to:

- Daily living and other adaptive functioning
- Behavior/emotional functioning, including any Behavior Support Plans, and/or
- Medical and related health needs.

If a Behavior Support Plan (BSP) is referenced in the consumer's current Support Plan and SC Annual Assessment, include a current signed and dated BSP in the packet.

If the consumer is a child receiving EI through BabyNet (i.e., not DDSN eligible), or is served by DDSN as a High-Risk Infant or At-Risk Child, the following support documentation must be included in the packet:

- A SCDDSN Eligibility Letter (if applicable).
- A current (within 3 months) curriculum based assessment.
- All available relevant medical, genetic and developmental reports. (This may include historical as well as current information).

After file review, the Consumer Assessment Team may return the request to you and request that the potential waiver individual be tested by a SCDDSN approved provider psychologist. The Consumer Assessment Team may also request additional records or reports prior to completing the LOC evaluation.

If a Community Supports Waiver slot has been allocated, and the Level of Care Determination is requested at the same time as a request for a determination of eligibility for services, the eligibility decision will be completed first. In this case, duplicate packets are to be sent to the Consumer Assessment Team, with corresponding coversheets for eligibility and Level of Care.

Please note: The SCDDSN Consumer Assessment Team has the discretion to request that an individual's current eligibility be reevaluated prior to completion of a Level of Care Determination request if, after file review, there is a question as to the appropriateness of the individual's current eligibility category.

Once the information is received, the Consumer Assessment Team will hold a meeting during which the Level of Care determination will be made. If you wish, you may attend this meeting. To do so, you must notify the Consumer Assessment Team in writing of your desire to attend. The Consumer Assessment Team should render a decision regarding Level of Care within ten (10) calendar days of receipt of the **Request for Community Supports Level of Care (Community Supports Form 9)** and all needed information.

When the Level of Care determination has been made, the Consumer Assessment Team will certify that the person does or does not meet ICF/IID Level of Care criteria. This is done by completing the **SCDDSN Level of Care Certification Letter** and mailing the completed letter, with the procedure for appeals printed on the reverse side, to the individual or his/her family or legal guardian and a copy to you. The Consumer Assessment Team is also responsible for providing the Waiver Enrollments Coordinator with the Level of Care information needed for

enrollment. In addition to the Certification Letter, you will receive additional forms (e.g., **Level of Care Determination for ICF/IID and Level of Care Staffing Report – Community Supports Form 7**) that have been used by the Consumer Assessment Team to determine whether or not ICF/IID Level of Care was met. These forms, along with the Certification Letter, should be kept in the individual’s file (this information should always remain in the file and NEVER be purged).

Individuals Who Do Not Get Enrolled within 30 days of the Initial Level of Care Determination:

Waiver Enrollment must occur within thirty (30) calendar days of the Level of Care Determination date. (Please see “Enrollments” for more specific information). If the potential individual’s Level of Care Determination was completed thirty (30) calendar days or more prior to waiver enrollment, a new SCDDSN Certification Letter must be issued. If a Waiver applicant’s Level of Care has expired prior to enrollment in the Community Supports Waiver, **a recertification does not have to be done immediately.** As long as enrollment occurs within 180 days of the initial Level of Care, it may be recertified/updated once all enrollment issues have been resolved

NOTE: If more than 180 days has passed since completion of the initial Level of Care Determination, then a new initial Level of Care Determination is required **prior to enrollment.** Please utilize the following steps for Community Supports Waiver Level of Care recertification:

1. Immediately contact the Waiver Enrollments Coordinator when you note that a Level of Care is about to expire or has already exceeded thirty days.

Please note: If the Waiver Enrollments Coordinator has completed all paperwork regarding the enrollment and the request has been submitted to DHHS, there is no need to re-certify the Level of Care. This may be determined by checking the enrollment status on the Waiver Tracking system under ENINS. If the enrollment status indicates “awaiting” then the request has already been submitted to DHHS and re-certification is not required.

2. The Waiver Enrollments Coordinator will verify that all enrollment information is completed. If so, you may request recertification of the Level of Care. If the case is not ready for enrollment, the Waiver Enrollments Coordinator will contact you when the Level of Care needs to be recertified/updated.
3. Prior to requesting the recertification from the Consumer Assessment Team, you must contact the individual/family/guardian. **Verify and document in your service notes that the individual’s condition has not changed since completion of the Initial Level of Care Determination.**

4. Review the Level of Care Determination Form and the supporting documentation upon which the initial Level of Care was initially completed.
5. Determine if the record contains more current reports or other information that might impact the answer to each specific question on the Level of Care Determination Form.
6. Then contact the individual/family/guardian to verify the current status of the individual and that the individual's condition has not changed to the extent that it would change the Level of Care decision. **This must be clearly documented in the individual's file and in a notation to the Consumer Assessment Team.**
7. If the individual's condition has not changed, please contact the Consumer Assessment Team via telephone and request a Level of Care recertification/update. You must resubmit via fax, a **new Request for Community Supports Level of Care (Community Supports Form 9) [indicate on the form that it is an initial LOC (expired) and enrollment did not occur with 30 days of the LOC effective date]**, the initial **Level of Care Determination for ICF/IID** form and the **Certification Letter** along with a request for issuance of a new Certification Letter. You must also include on the fax cover sheet that the individual's condition has not changed and with whom you verified that information, so that the Consumer Assessment Team may complete the recertification/update. You must verify that the individual is ready for enrollment by consulting with the Waiver Enrollments Coordinator (Attachment 1 in Chapter 6) prior to contacting the Consumer Assessment Team. The Waiver Enrollments Coordinator will notify the Consumer Assessment Team via e-mail that the individual is ready for enrollment into the Community Supports Waiver once all of the enrollment issues are resolved.

Once the recertification is completed by the Consumer Assessment Team, you will receive a new Certification Letter along with the updated Level of Care Determination for ICF/IID Form. When the initial Level of Care is updated, the date of the update becomes the **new effective date** of the Level of Care. To document that the initial Level of Care was updated, the Director of the Consumer Assessment Team will sign, date and notate "update" on the initial Level of Care Determination form below the signature line and a new Level of Care Certification Letter will be completed. The Consumer Assessment Team will notify the Waiver Enrollments Coordinator of the new Level of Care date.

Once the Level of Care has been recertified, it CANNOT be recertified again. If the individual is not enrolled in the Community Supports Waiver within thirty (30) days of the recertification, then a new Level of Care packet must be submitted to the Consumer Assessment Team.

8. If the individual's condition has changed, a new initial Level of Care packet must be submitted to the Consumer Assessment Team. The team should be apprised via telephone as to why this Level of Care is being requested. You should determine what current reports or other information is needed that might impact the answer to each

specific questions on the Level of Care Determination Form, obtain these records and add them to the original packet that was submitted to the Consumer Assessment Team. A new **Request for Community Supports Level of Care (Community Supports Form 9)** must be completed.

Please note: the Consumer Assessment Team has the discretion to deny a recertification and ask that a new initial Level of Care packet be submitted.

ICF/IID Level of Care Reevaluations/Redeterminations for Individuals Enrolled in the Community Supports Waiver:

Once enrolled, ICF/IID Level of Care evaluations are valid for up to 365 calendar days unless otherwise stipulated by the Consumer Assessment Team, but can never be more than 365 calendar days. Each individual must be evaluated at least every 365 calendar days from plan date (or as needed given changes in condition, diagnosis, etc.) and certified to meet ICF/IID Level of Care in order to continue to receive services funded through the Community Supports Waiver. You will be responsible for these annual re-evaluations and certifications **except for those individuals who are eligible on a time-limited basis. For those who are served in a time-limited basis under the eligibility categories of Mental Retardation, Related Disability, At-Risk Child, or High-Risk Infant, the Level of Care re-evaluation must be completed by the Consumer Assessment Team. The same information required for an initial Level of Care evaluation plus the most recent Level of Care Determination for ICF/IID and Certification Letter must be sent to the Consumer Assessment Team**

For all other individuals, you are responsible for the annual re-evaluation of ICF/IID Level of Care. These re-evaluations must be conducted within 365 calendar days of the previous Level of Care Determination/Assessment date. The review will, **at a minimum**, consist of a review of the most recent psychological, social and medical information along with a review of the current IFSP/FSP, Support Plan, and/or IEP. Based on the review of the information, you must complete the **Level of Care Determination for ICF/IID**.

If a participant still meets ICF/IID Level of Care, the SCDDSN Level of Care Certification Letter does not have to be completed unless certification is for less than 365 calendar days.

All decisions must be reviewed by your Supervisor or the Executive Director of your DSN Board/Provider. All Level of Care re-evaluations must be documented along with the **review from the Supervisor or Executive Director**. Once the Supervisory review is complete, the Level of Care Certification Letter (if applicable) and/or the Level of Care Determination for ICF/IID should be placed in the individual's file. **If the individual continues to meet ICF/IID level of Care, you do not have to submit the original Level of Care Certification letter to the individual and his/her family/guardian.**

If the individual is found to meet ICF/IID Level of Care, you must enter the effective date into the Waiver Tracking System. This should be done within one (1) working day of the determination. This should be done within one (1) working day of the determination. To do so, log in to the Waiver Tracking System, select the “enrollment menu” (ENMEN), then select “Update Last Loc Reeval Date” (ENLDT) and enter the participant’s name or ID number. Next, enter the effective date of the re-evaluation certification.

If the individual is found to not meet ICF/IID Level of Care, all information used to make this determination along with the completed Level of Care Determination for ICF/IID **and the SCDDSN Level of Certification Letter** must be submitted to the Consumer Assessment Team along with a **Community Supports Form 9** (indicate found to not meet ICF/IID LOC by DSN Board/Provider on form) requesting a review of the decision (do not send notice to the individual/legal guardian at this time. These materials must be sent to the Consumer Assessment Team far enough in advance to allow them to complete the review the review of the determination prior to the expiration date of the current certification. If the Consumer Assessment Team concurs with the determination that the individual does not meet ICF/IID Level of Care, the Consumer Assessment Team Director will sign the Level of Care Determination for ICF/IID and the **SCDDSN Level of Care Certification Letter** and mail the **SCDDSN Level of Care Certification Letter**, with the procedure for reconsideration and appeal printed on the reverse side, to the applicant or his/her family or guardian and send a copy to you. You must keep all documentation regarding this decision in the individual’s file. Please note that if an individual no longer meets ICF/IID Level of Care, then he/she can no longer participate in the Community Supports Waiver. Therefore, you would initiate procedures for disenrollment (See Chapter 7 for instructions).

Note: If the current Level of Care certification expires, and consequently, the consumer must be disenrolled from the waiver while the Consumer Assessment Team is reviewing a determination that found him/her to no longer meet ICF/IID level of Care, his/her waiver-funded authorizations must be terminated; however, the services will continue during the Consumer Assessment Team’s review at the provider’s expense.

If the individual is found to not meet ICF/IID Level of Care, and the Consumer Assessment Team **does not concur** with the decision, the decision will be overruled. The Consumer Assessment Team will signify their disagreement with the decision by completing a new **Level of Care Determination for ICF/IID and SCDDSN Level of Care Certification Letter** and returning it to you. You must keep all documentation of this decision in the individual’s file.

Note: If for some reason the eligibility of an individual enrolled in the Community Supports Waiver changes to a non-eligibility status for Mental Retardation or Related Disability, you must complete a Level of Care Re-evaluation which is warranted anytime an individual’s condition changes. Given this new eligibility information, the individual would not meet Level of Care since Level of Care requires a diagnosis of Mental Retardation or Related Disability. Therefore, you must submit the adverse Level of Care Determination Request to the Consumer Assessment Team as previously noted in this chapter. **You cannot disenroll an individual from the Community Supports Waiver solely based on an eligibility decision. A Level of Care re-evaluation must be done and this decision upheld by SCDDSN through the SCDDSN**

reconsideration process. If the participant then files an appeal w/SCDHHS, Division of Appeals and Hearings, and the LOC Re-evaluation decision is upheld, then the participant can be disenrolled from the CS Waiver.

**South Carolina Department of Disabilities and Special Needs
Community Supports Waiver
Consumer Assessment Team Request for ICF/IID Level of Care**

Date: _____

Individual: _____

Individual's Address: _____

County of Residence: _____

Medicaid #: _____

SSN#: _____

Board/Provider: _____

Dist. Office Rep/QMRP: _____
(for ICF/IID individuals)

SC/EI and phone #: _____

SC/EI E-mail address: _____

LOC Request	Eligibility Category
<input type="checkbox"/> Initial LOC (First time sent to CAT)	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Initial LOC (Individual Disenrolled/Seeking to re-enter the Community Supports Waiver)	<input type="checkbox"/> Related Disability _____ Specify
<input type="checkbox"/> Initial LOC (expired)	<input type="checkbox"/> High Risk Infant/At Risk Child
<input type="checkbox"/> Enrollment did not occur within 30 days of LOC effective date	<input type="checkbox"/> Spinal Cord Injury
OR	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Over 365 days old	<input type="checkbox"/> Similar Disability _____ Specify
Copy of last LOC dated _____ (Included with packet)	
<input type="checkbox"/> Annual Re-evaluation for time limited eligibility only	
Waiver Enrollment date: _____	
Time Limited eligibility expiration date: _____	
Copy of last LOC dated _____ (Included with packet)	
<input type="checkbox"/> Found to not meet ICF/IID LOC by the DSN Board/Provider	

Waiver Enrollment Information (for Community Supports only)

Has this person been institutionalized? Yes No

Did this person begin waiver services immediately following move from ICF/IID? Yes No

Date Freedom of Choice (Community Supports Form 1) signed: _____

TO BE COMPLETED BY CAT LOCATED AT THE MIDLANDS FIELD OFFICE

Level of Care Effective Date: _____ **Found to not meet ICF/IID Level of Care**

SC, EI or District Office Rep

Service Coordinator/Early Intervention Supervisor

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

COMMUNITY SUPPORTS WAIVER

LEVEL OF CARE CERTIFICATION LETTER

TO: _____ COUNTY OF RESIDENCE _____

SS#: _____ MEDICAID # _____

LOCATION OF ASSESSMENT: _____

The South Carolina Department of Disabilities and Special Needs has evaluated the information submitted by your physician and other professionals and has determined that:

- () according to Medicaid criteria, you do not meet medical requirements for Intermediate Care for the Intellectually Disabled. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility.
- () according to present Medicaid criteria, you meet requirements to receive long term care at the following level:
 - () Intermediate Care Level for the Intellectually Disabled

This letter must be presented to the facility to which you are admitted.

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

If you disagree with this determination, please read the reverse side of this notification.

EFFECTIVE DATE: _____ EXPIRATION DATE _____

SIGNATURE/TITLE

DATE OF ASSESSMENT

COMMUNITY SUPPORTS

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for authorizing some Medicaid State Plan services for Intellectual Disability/Related Disabilities (ID/RD) Waiver, Community Supports (CS) Waiver and Head and Spinal Cord Injury (HASCI) Waiver participants. A request for reconsideration of an adverse decision **must be** sent in writing to:

SC Department of Disabilities and Special Needs
Attn: State Director
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process **must be** completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

**COMMUNITY SUPPORTS WAIVER
LEVEL OF CARE DETERMINATION FOR ICF/IID**

NAME _____ ID _____ DOB _____

1. Person has: (at least one of the following)

- a) MR: _____ Yes _____ No
- b) Related Disabilities: _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ Date _____

AND

2. Supervision is necessary due to: (at least one of the following)

- Impaired judgment/limited capabilities _____ Yes _____ No
- Behavior problems _____ Yes _____ No
- Abusiveness _____ Yes _____ No
- Assaultiveness _____ Yes _____ No
- Drug effects/medical monitorship _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ Date _____

AND

3. Services are needed for: (at least one of the following)

- a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No
- b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ Date _____

APPROVED FOR ICF/IID LEVEL OF CARE

_____ Yes _____ No

_____ Initial Determination

_____ Annual Recertification

_____ Other (specify)

Signature/Title

Date

COMMUNITY SUPPORTS

Revised 1/13

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORTS WAIVER
LEVEL OF CARE EVALUATION

STAFFING REPORT

Individual's Name: _____

Social Security #:

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The above named individual has been determined by the Office of Individual Assessment to

meet not meet

the Medicaid Level of Care criteria for ICF/IID.

Team Member Signatures:

Physician Signature and Date:

Evaluation Date: _____